PANEL DISCUSSION: IMPLEMENTING CHANGES WITHIN THE ACADEMIC MEDICAL CENTER*

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DR. STANLEY RECHMAN: Some patients are quite aggressive and on their own initiative demand and receive information from physicians which they use to change their own health behavior. A large group of patients are also very passive. One necessary approach is to teach patients how to ask for appropriate health information. Patients who learn to demand such information can change their own behavior and also may influence changes in the behavior of physicians or other members of the health care team who may be assigned to meet their information needs.

DR. LEWIS: Dr. Sheldon Greenfield has been conducting a randomized control trial of the results of providing patients with their records. A group of patients with ulcers are given assertiveness training and are thus prepared to confront their physicians on the methods and results of treatment. So far, we have found a reduction in disability among this group of patients. Although I am not sure about the reasons, we have noted that this process is more distressing to the physician than it is to the patient. In another project we have taught decision-making skills on health to children in our elementary schools. However, a problem exists in that some parents believe that this kind of teaching is a responsibility of the family, and I can sympathize with this position. One has to examine the cultural consequences of patient education or the turbulence that is produced lest we produce more adverse effects than positive results.

UNIDENTIFIED SPEAKER: There is often a difference between the patient's perception of his problem and the physician's perception of the patient's problem. The physician often thinks the patient's basic problem is psychosocial,

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behavioral, or psychosomatic. The patient, on the other hand, perceives his problem to be a physical one. When that kind of a disparity exists one must have better communication.

DR. ROBERT WEISS: It is estimated that 75% of the average physician's time is now spent with patients over 65, and by the year 2000 some 90% of all physicians' time will be devoted to patients in that age group. Talcott Parsons has suggested that one of the major functions of the physician is to legitimize the patient in the sick role. This permits the patient to be relieved from the role responsibilities of an active job and to obtain relief from the pressures and stresses that job entails. This may be fine for the average patient, but what of a geriatric patient who, because of retirement, has already been removed from society's expectations of role responsibilities except for his own care. An illness brings increasing disability which threatens the patient's remaining independence, diminishing the patient's ability to care for self. The result is depression and a further sense of helplessness and worthlessness. Alternatives left to the patient are to comply and give up an active life or to deny his illness role and to fail to comply. What is the role of patient education in this situation which is going to become increasingly more important?

MR. MERVYN SUSSER: The sick role is changing in society. The original model of the sick role that was developed by H.E. Sigerist is characteristic of the time when the prevalent form of disorder was acute illness and not chronic ambulatory sickness. I agree with Dr. Weiss that we do have special problems arising from the growing numbers of older people. Dr. Weiss' point is supported about the prevalence of denial. Many elderly people who have illness, impairment, or diseases deny they have an illness. The major point is to discriminate according to situations which are often complex and between a disease process flowing from an impairment and the subjective state of perception and whether we are dealing with problems in role performance.

DR. HOWARD L. WAITZKIN (North Orange County Community Clinic, Anaheim, CA): In reference to assertiveness training, for a number of years I have been conducting studies in patient education focusing on the sociolinguistic problems of working class patients. These patients are very diffident about asking questions in medical encounters. The social class difference in language use has been very well documented in sociolinguistics both in Britain and the United States. This is one of the most troubling aspects of patient education. Our perceptions of patient needs are class linked, relating to our background as practitioners and to the background of our patients.

There is no class difference in patient's desire for information, yet as health workers we attribute different desires for patients from a lower class or lower educational background. This major misconception is one of the major barriers in effective communication. How can we create changes in patient education without addressing the broader issues of social structures?

DR. HERBERT BERGER (Staten Island, N.Y.): I speak as a practicing physician in a neighborhood community. Let us assume by analogy that your television set stops functioning and a mechanic is called in. You ask him: "Can you fix the set? How much will it cost? How long will it take?" And if you are perceptive you might say, "Why did this happen," and "What's wrong with it?" And, if I am responsible for what went wrong with it, tell me how not to do it again, whereupon I become a recipient of education.

Now, this is what occurs in your office. The patient comes in and asks first, not "What do I have," but "Can I be well again?" The physician will reassure him that he can be well again if possible and if it is not possible he will indicate that he will relieve his discomfort and do as much as he can to get him better again. The goal appears on the wall of the Hotel Dieux in Paris: "To cure sometimes, to relieve often, and to comfort always." This has always been the job of the physician. We are always involved in patient education and the success of most practicing physicians is proof that they do this job fairly well. A patient who wants to know how long it will take to get well is given some idea about this and something about what it will cost. You inform him about the side effects of the drug he is going to use, so that he does not tell you after you have given him an antidepressant, "Gee, I can't take this stuff, Doc. I am just too dry when I use it." Since he is told in advance, his response is, "I guess this material is really working," and he then is willing to wait a couple of weeks for this depression to get better. Incidentally, if a patient asks, "What's really wrong with me," you don't tell him that he's got a depression. I don't think you should tell this to anybody. Again, this is part of patient education. Even if he has lost his wife recently and his business has gone bankrupt, you can't say, "Well, you have got every reason in the world to be depressed," because his reaction to this is that John Wayne would not be depressed over something like this. So one has to find a diagnosis that will fit that patient's concept of illness as well.

Teaching patient education at a medical school is almost impossible through lectures. This is a question of turf. Time will have to be carved out from

other departments in the medical school. There are some dangers to patient education because patients are not well informed people. Don't fall into the trap of thinking that because somebody is a professor of astronomy he is not a Neanderthal when talking about his own illness. He simply does not understand it either. And you simply cannot make a physician out of him in the few minutes you have to talk with him. Provide information pitched at a level that the patient can understand and explain that, yes, you have this illness and with your help I can get you better. These are the things you must do, and if necessary write down. I recall a young woman who came to me with a gastroenteric problem and it turned out that she was pregnant. She did not know this because she had always had irregular periods. She asked me a question when I told her about her diagnosis, which seemed a bit absurd. She asked, "Am I going to have a boy or a girl?" This seemed like a ridiculous question, so I answered, "Well, there are only two possibilities, aren't there?" She went home, and her husband telephoned me a few minutes later, very upset—first, to learn that his wife was pregnant and two, to learn that she was going to have twins!

The whole purpose of patient education in my judgment is to get the patient well. We want his compliance; we want him to follow rules. I shall use hypertension as an illustration to focus on a disease. Take a person who is feeling well, who has now been discovered to have hypertension. He will need to see a physician regularly at intervals, to take medicines for the rest of his life, some of which are highly unpleasant, which may make him feel lightheaded, or may even cost him his potency. From the point of view of the patient, he will ask "What am I doing all of this for? So I can live an extra 11 months in a nursing home forty years from now, or to prevent a stroke in the distant future?" Now you are going to require compliance from him. This is going to take all the skill you possess, a task that is more difficult than learning how to run an x-ray machine or how to find the square root of two. You will tell this patient, "Yes, you are going to have to endure all of these things and it is worthwhile." You may succeed in getting him to change his lifestyle.

We doctors in practice look upon these patients as partners and tell them, "I can make you better if you will help me." And, finally, the role model for all of us in medical schools is the clinical teacher who is in practice, who examines and talks to a patient as he would to one in his office. The students, interns, and residents will all learn how to do patient education from watching him.

DR. JOHN RENNER (St. Mary's Hospital, Kansas City, MO): One of the elements of patient education is an informed patient who knows how to select the appropriate medical facility and to understand how that facility functions. Some patients select academic medical centers as their place of care, may choose to go elsewhere because of problems of parking, lack of accessibility, lack of continuity of care; some patients in academic centers may even feel that they are being experimented on. I would like to point to a few elements of patient care that are important—the question of waiting time. A patient waiting at a facility for an hour to see someone is a different patient from one who has been taken care of immediately. In my office a sign says that if you are waiting longer than 15 minutes, please notify the receptionist. I am going to replace that sign with one in the next few months which says "If you are waiting longer than 20 minutes, this visit is free," because where I come from, we see busy people and competition among health centers is growing.

Another positive suggestion I would make is that to influence students and residents, one has to establish a patient advisory group and get patients involved in communicating. Academic centers do not need another administrative level to deal with patient education but have to develop a format for honest interchange with groups of patients because patients interact differently in a group than they do as individuals.

DR. LOREN WILLIAMS (Medical College of Virginia): In the Medical Colleges of Virginia we have a complex family practice arrangement. One of the family practice centers serves patients from a lower socioeconomic level. Attending physicians at this center were very concerned about their ability to establish good communication with patients about chronic obstructive pulmonary disease. Passing out pamphlets dealing with smoking cessation produced no results. After looking at how patients received information, we put together a TV tape with two fishermen with pulmonary disease talking with each other about their disease. This tape did break the ice and stimulated discussions between patients and physicians. Some years ago, at the Medical College of Georgia in a project providing services to high risk pregnancy patients from a primarily rural black population, we were able to facilitate communication by preparing a TV tape in which the leading protagonist was a black nurse.

DR. MARK SIEGLER (University of Chicago Medical School): I invite the panelists to state in a sentence or two what they mean to be the primary goal patient education by physicians. The following is a start.

of patient education and then after they make their presentations I would like to provide a two sentence statement on what I take to be the primary goal of patient education.

DR. HAYNES: I think that the goal of public health education is to make the relationship between therapist, diagnostician, and patient more effective so that the diagnostician understands the patient and the patient understands the problem that he faces in terms of its biological, social, and psychological aspects.

DR. OLIVE: Patient education is patient-physician communication. It is incumbent upon each to understand what the other person is about—to understand what the patient is being told and to understand where the patient is coming from, and for the patient to understand what the physician is trying to get across. If there is understanding on the part of the physician why the patient does not take his medication and if the patient understands the consequences of not taking that medication, then patient education has taken place. The issue is not compliance. Compliance is an end point. Some people may not want to comply and that is fine so long as they understand the consequences of their failure to comply.

DR. SUSSER: I would not dissent but I would add two aspects. It is not possible to ignore content and we also have to emphasize learning the skills of communication. We need to develop as solidly as possible the scientific basis of what we are conveying, to know the extent and limits of science, and not to hold back the truth as we know it. We mediate this by the skills of communication that we acquire. The other issue that we should deal with is influencing behavior outside the patient-physician role, and that deals with promoting the future health of the population to the best of our ability. The way to do that is not through the patient-doctor situation or in the medical institution but in the society as a whole.

DR. BRIAN HAYNES: When I speak of patient education, I refer to patient-physician interaction where there is a partnership in which we are trying to resolve the problem the patient came in with. The patient presents an acute problem that has to be addressed, which involves curative and preventive aspects. I dislike the term "compliance." I like the term "partnership between the patient and the physician." I agree that the essence of patient education is communication.

DR. THOMAS S. INUI: The goal of patient education is to inform the patient within the limits of our medical knowledge and to encourage patient comprehension and participation to the degree that patients can participate

in health care decisions both as to cure and prevention. Compliance is an inadequate end point for that kind of involvement of the patient in decisions. The imperatives to do patient education are legal, psychological, ethical, and medical. Failure to perform that role undermines the entire purpose of the medical mission.

UNIDENTIFIED SPEAKER: Patient education is a skill which assists the patient to help him make decisions regarding his health status.

DR. SIEGLER: I am not sure that those of you who use the term skill or communication understand it. We are not only dealing with the skills of communication—we are talking about understanding and knowledge about what needs to be communicated and what needs to be learned. When we use a term like skill or communication alone we underplay the full scale of what is involved in effective education.

DR. IRVING LEWIS (Albert Einstein College of Medicine): The academic medical center is unavoidably living in the world of the university, and the world of society and its funding depends very much on public sources. Since the population served by the academic medical center is increasingly burdened by chronic illness and the problems of aging, the academic medical center must shift its priorities to stress patient care and community service and within that framework patient education performs a very important function. This may not have been the case 25 years ago when medical schools got their support from different sources. Today the situation is changed; the academic medical center must focus on the health of the population of a designated, defined area and, when it is so focused, then educators have the responsibility to determine the mechanics and modalities of patient education. It takes central leadership to get financial systems to change, and the financial system will not change unless the medical center leadership recognizes that it lives in two worlds and chooses to be responsive to the two worlds. There are now going to be increasing battles over the dollar. When we first discussed plans for this conference, I said the key issue is what is the role of the medical center with respect to patient care. When that is settled, the issue of what is to be done about patient education becomes clear.

DR. RITA WROBLEWSKI (Pfizer Pharmaceuticals): If I may, I would like to synthesize some of the points of view expressed, especially those dealing with the academic medical center's responsibility for patient care and the suggestions about the role of the private clinician in patient care, and the changing role of the academic medical center in teaching research. In the last 25 years the full-time faculty in medical centers with major com-

mitments in research and lesser commitments to patient care has emerged as the most important force. The clinician does not have a significant role to play and is no longer part of the power and prestige pyramid of the center. This must change and the clinician has to have a more pivotal role. I do not want to malign high technology. If there is a choice between a doctor who can hold our hand and one who could give us a shot of penicillin when we have pneumonia, we would opt for the shot of penicillin. We need to synthesize relevant skills more effectively, however. It would be helpful if we could develop a follow-up to this meeting by developing a statement with which we could all agree which could include a discussion of examples of workable implementation of patient education.

ANNE R. SOMERS (Rutgers Medical School): The goal of patient education is to help the patient assume as much responsibility for his health as he can possibly achieve. All of the other things such as communication, doctor-patient relationships, and written prescriptions are instruments toward that goal. Patient education must include, as Dr. Haynes said, patient feedback. The present reward system in medicine works to the contrary. It rewards technological procedures as opposed to cognitive procedures and this is supported by the public, especially in the Medicare structure of benefits and in what the workers bargain for in their health benefits from management. There is a lack of emphasis on long-term care and prevention. Medical schools and the medical school curriculum are hostage to financial problems of the teaching hospitals. Deans and other dedicated people have had to bend to these pressures and move away from primary care and patient education to more emphasis on the superspecialties to get the funds necessary to support the current system. Urging deans to be more interested in primary care and patient education is not the answer. What I have missed in this discussion is a lack of emphasis on *money*. How do we change the financial incentives, the benefit structures of Medicare, and the relative value scales by which organized labor structures its own system? If we do not come to grips with financial incentives, whatever we say today will be ephemeral.

MR. CHARLES COHEN: For patient education to be successful those of us who provide health services need to look to our own attitudes. We have to appreciate that patients are able to function in many areas despite their illness and disability. Unless we really believe that patients are capable of learning, no patient education will take place.

DR. EMILY MUMFORD (University of Colorado School of Medicine): I am very impressed with the extent to which sensitive listening to the patient or

family members has resulted in improved patient education. These successes are related to listening attentively. I would suggest that the reward system in medical education does not reward listening; it rewards talking. We have a tendency not to listen to the student about his education nor to listen to the intern or resident about what they are experiencing.